Letters

Solitary caecal diverticulitis

Editor,

I have had recent experience of three cases of solitary caecal diverticulitis which presented over an 18 month period to Causeway Hospital[1] and wished to add to the case by Abogunrin *et al*.[2] There have been over 1000 cases of caecal diverticulitis reported in the literature. A review of 881 cases showed that the average age was 43.6 years (range 7 to 87 years) with a 3:2 male to female ratio.[3] 85% present with symptoms similar to appendicitis.[3] Cutajar[4] suggested clinical features which could help differentiate caecal diverticulitis from appendicitis. There is a relatively long history of abdominal pain with lack of toxicity. Tenderness is not as marked and only elicited on deep palpation, and vomiting is less frequent. Abogunrin *et al*[2] suggested that CT scanning was the most useful pre-operative investigation as ultrasound was not sensitive. However, Chou[5] proved the accuracy of ultrasound in diagnosing caecal diverticulitis. In a prospective study of 934 men with indeterminate right lower abdominal pain, ultrasound had a sensitivity of 91.3% and a specificity of 99.5% in differentiating right sided diverticulitis from appendicitis. Ultrasound also has the advantage of avoiding radiation exposure and being generally more accessible. Given the low incidence and difficulties with diagnosis, there have been no randomised trials comparing conservative with aggressive treatment. Most studies are retrospective note reviews comparing outcomes in those treated with antibiotics alone to diverticulectomy or hemicolectomy, and also tend to be from mainly Asian populations, which may not be truly representative of the UK.

Lane *et al*[6] in a study of 49 patients with 78% of non-Asian descent, found that 40% of those treated with diverticulectomy or antibiotics alone required subsequent hemicolectomy due to an ongoing inflammatory process. In a US population, they recommended diverticulectomy in cases of a solitary inflamed diverticulum. Our cases, treated with diverticulectomy or inversion of the diverticulum had no postoperative complications or recurrence of symptoms. We agree with Abogunrin *et al*[2] that surgery should be conservative when carcinoma is excluded and there is not extensive inflammation.

The author has no conflict of interest

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Benign Headache in the Elderly – A Case Report of Hypnic Headache

Editor,

New headaches in the elderly raise the suspicion of serious pathology such as space occupying lesions, temporal arteritis, or cerebrovascular disease. Alternatively such headaches may simply represent the re-emergence of a previous headache such as migraine. However, benign headache syndromes are increasingly being recognised in this population.

The Hypnic Headache Syndrome (HHS) is a rarely reported disorder of the elderly characterised by recurrent nocturnal headaches of moderate severity that waken patients in a predictable pattern.

Case Report A 79 year old man had a four week history of headaches occurring predictably 2-3 hours after falling asleep and lasting for about one hour, during which time he sat up believing that this relieved the headache. This recurred every night, once or twice per night, with no daytime headache. He described it as a 'choking, full' headache, distributed 'like a cap'. It was associated with mild nausea but no vomiting or other autonomic features. There was no previous history of headaches.

Past history included ischaemic heart disease, a previous basal ganglia lacunar infarct, controlled epilepsy, hypertension, osteoarthritis, diverticulosis, prostatic hypertrophy, peripheral vascular disease and chronic renal impairment. Examination was normal.

Initial investigations revealed creatinine 134, sodium 129. Hyponatraemia was felt secondary to carbamazepine; a synacthen test and thyroid function were normal. Sodium subsequently normalised. Chest X-ray was normal and a CT scan of Brain showed mild cerebral atrophy and the previous infarct. Other investigations included a normal US abdomen/pelvis, normal CT chest/neck, normal FBP, Liver function tests, C reactive protein, CEA, CA19.9, PSA and urinary catecholamines.

Based on the above we diagnosed Hypnic Headache Syndrome and commenced the patient on 200mg lithium carbonate. Within 48 hours there was sustained complete resolution of the headache. After discharge the general practitioner discontinued the lithium because of concerns about drug interactions, and the headaches returned. Simple analgesia was substituted but headaches continued.